



OneCare Vermont

**2022**

**Budget Presentation to**

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**Green Mountain Care Board**

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Sara Barry, COO; and  
Tom Borys, Vice President of ACO Finance  
November 10, 2021

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# **Budget Section 1**

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## **ACO Information and Background**

# Budget supports continuous advancement towards **value-based care**

## ■ Growing Statewide Attribution

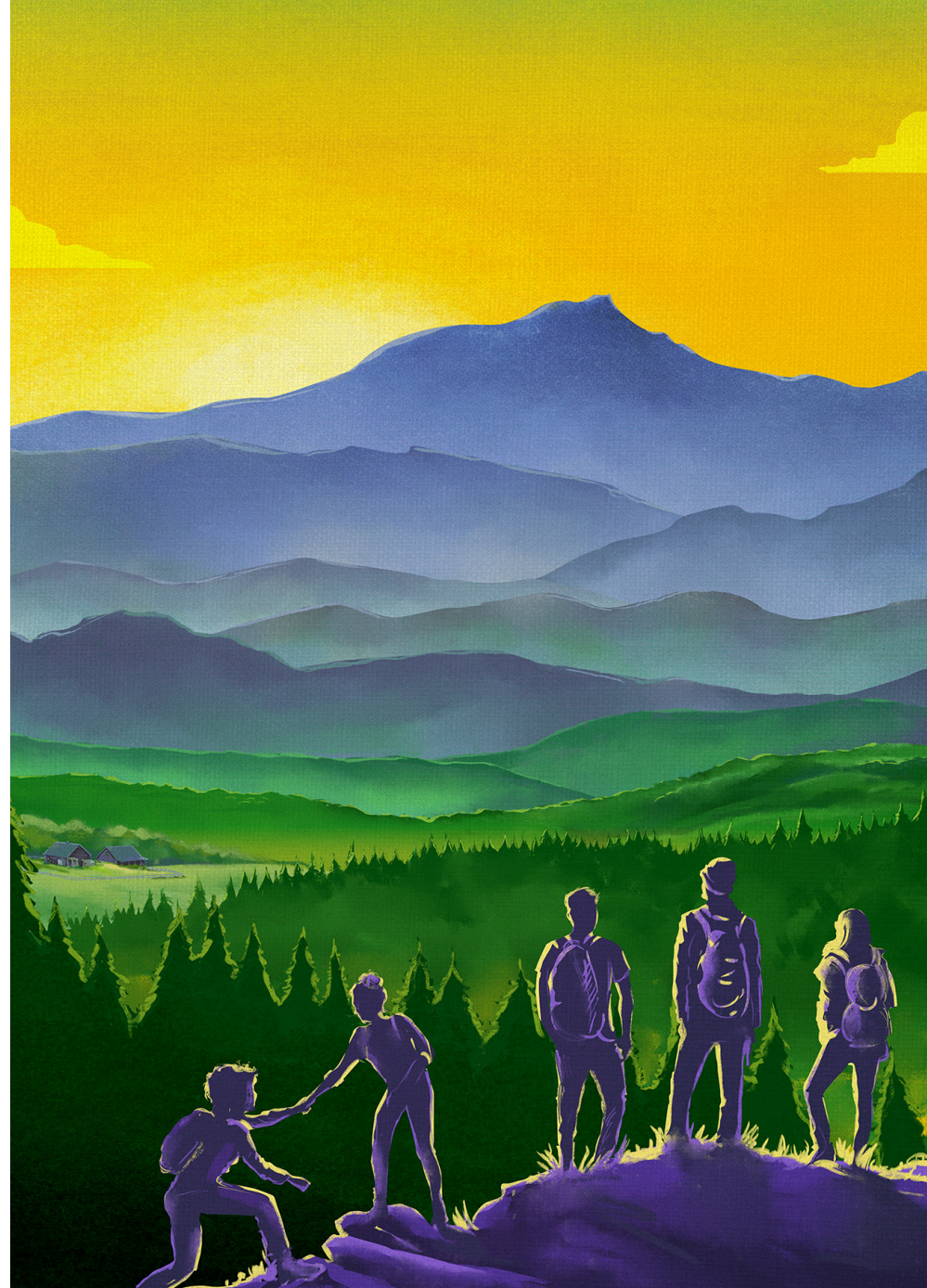
- Increasing number of engaged providers
- Over 5,000 providers statewide and over 90% of eligible primary care

## ■ Continuous population health investments

- \$28.9 million direct payments to providers
- Growing engagement in independent primary care model

## ■ Growing conversion from fee-for-service to value-based care

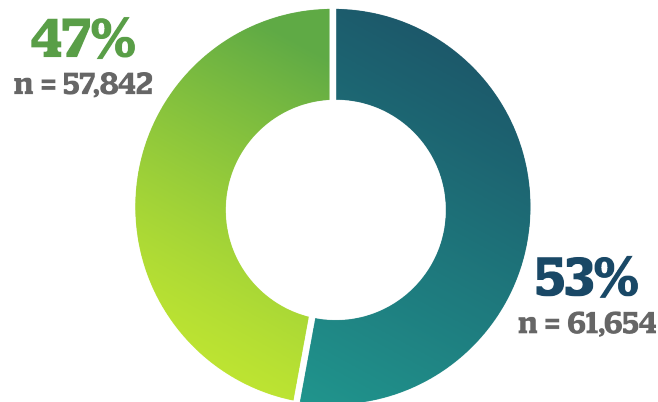
- \$1.3 billion of existing healthcare dollars (Half of VT's eligible health care spend in model)
- 100% in advanced payment model



**“CMS wants *every* Medicare Beneficiary to be in an accountable care relationship by 2030.”**

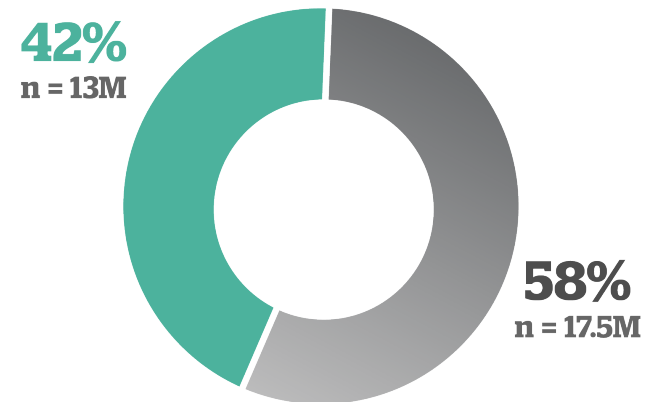
## **2020 Medicare Beneficiaries in Accountable Care Relationships Vermont vs. National**

**Vermont** Traditional Medicare Beneficiaries in an ACO



VT Medicare FFS beneficiaries in an ACO  
VT Medicare FFS beneficiaries not in an ACO

**National** Traditional Medicare Beneficiaries in an ACO



National Medicare FFS beneficiaries in an ACO  
National Medicare FFS beneficiaries not in an ACO

Chart source: CMS White Paper on CMS Innovation Center’s Strategy: Driving Health System Transformation - A Strategy for the CMS Innovation Center’s Second Decade; <https://innovation.cms.gov/strategic-direction>; published October 2021



# Positive Evaluation: Vermont's APM Progress

*by NORC at the University of Chicago*

## Key Takeaways from CMS Findings



**Statistically significant  
Medicare gross  
spending reductions**



**Declines in  
acute care stays and  
30-day readmissions**

The evaluation of the first two years of the model was conducted by [NORC at the University of Chicago](https://innovation.cms.gov/data-and-reports/2021/vtapm-1st-eval-full-report), an independent research institution, and assesses the implementation and measures effects of the APM. Report: <https://innovation.cms.gov/data-and-reports/2021/vtapm-1st-eval-full-report>; <https://innovation.cms.gov/data-and-reports/2021/vtapm-1st-eval-report-aag>

# OneCare's Core Capabilities



**Network Performance  
Management**



**Data and  
Analytics**



**Payment  
Reform**

# Provider Perspectives

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- COVID-19's impact on care
- ACO as a vehicle to move forward
- Innovation required to do business
- Care coordination evolving
- Abundant opportunities for collaboration



# **Budget Section 7**

**ACO Quality, Population Health,  
Model of Care, and  
Community Integration**



# Core Capability: Network Performance Management Quality and Care Model



## Network Contracting

- 5,060 providers
- 288,000 attributed lives
- Full continuum of care

## Quality

- Focused quality strategy
- Practice-level quality reporting
- Incentives for high-quality care

## Care Model

- Population health model
- Prevention
- Care coordination

# Core Capability: Network Performance Management Quality



## Value-Based Incentive Fund (VBIF)

### Quality Focused Areas *determined in 2021:*

Hypertension  
Diabetes  
Depression Screening  
Developmental Screening

**54** primary care  
organizations

were provided with data to help them understand how they are doing compared to national benchmarks on these quality focus areas. Incentives are tied to providing higher quality of care.

**\$2.2M**  
of hospital funding  
*allocated twice per year  
based on performance*



### Medicaid VBIF Results (2021 Q1)

		Hypertension	Diabetes	Dev Screening	Depression
TIN	Met Target	49%	65%	95%	79%
	Met Stretch Goal	23%	35%	84%	5%
HSA	Met Target	50%	79%	92%	58%
	Met Stretch Goal	14%	43%	83%	0%
OneCare Aggregate		Below Target ●	Met Target ●	Met Stretch Goal ●	Met Target ●

# Core Capability: Network Performance Management Quality



## VBIF, *continued*

### 2021 VBIF Q1 - PEDIATRIC MEASURES

ORGANIZATION	DEPRESSION SCREENING		DEVELOPMENTAL SCREENING	
	COMMERCIAL	MEDICAID	COMMERCIAL	MEDICAID
Green Primary Care	●	●	●	●
Mountain Pediatrics, PC	●	●	●	●
Pondside Pediatrics	●	●	●	●
Miller Health Partners, Inc.	●	●	●	●
Hospital and Health Center Inc.	●	●	●	●
Smith Hospital	●	●	●	●
ABC Pediatrics	●	●	●	●
Vermont Regional Hospital, Inc.	●	●	●	●
The Medical Center Inc.	●	●	●	●
Pediatrics and Other Medicine	●	●	●	●
123 Hospital, Inc.	●	●	●	●
Down the Street Pediatrics	●	●	●	●
NE Kingdom Pediatrics	●	●	●	●
Royal Partners Peds	●	●	●	●
SE Vermont Pediatrics	●	●	●	●
Medical Center Inc.	●	●	●	●
Valley Pediatrics	●	●	●	●
<b>OneCare Aggregate</b>	●	●	●	●

● Met Stretch Goal  
 ● Met Target Goal  
 ● Below Target Goal

**MOCK DATA**  
Not for Interpretation

You are invited to learn more at the upcoming VBIF webinar, scheduled for November 3rd, from 12pm to 1pm. See OneCare Network News for details.  
If you have any questions or concerns, please contact your assigned OneCare Quality Improvement Specialist, noted at left.

# Core Capability: Network Performance Management

## Care Model



## Care Coordination Program

### Participant Survey: Care Model

Received 121 responses from Area Agencies on Aging, Designated Agencies, FQHCs, home health and hospice agencies, hospital-owned and independent primary care, SASH, and VCCI.

#### Actions Taken:

- Re-evaluated Care Navigator
- Conducted two trainings on motivational interviewing
- Developed a 2021 education plan



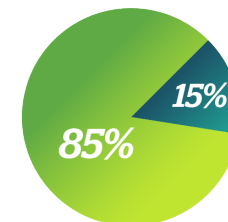
### Affirmed

- ✓ Person-Centered Care
- ✓ Community Team Based Care
- ✓ Shared Care Plans
- ✓ Lead Care Coordinator
- ✓ Care Conferences
- ✓ Shared Communication Platform

### 2022 Payments:

No Longer  
Linked to  
Care Navigator

### Payments have two components:



- Base Payment for Network Accountabilities
- Incentive Based on Performance



# Core Capability: Network Performance Management Care Model



## Care Coordination, *continued*

### Sub-population Areas of Focus



Frequent use of  
the emergency  
department



High inpatient  
hospital  
utilization

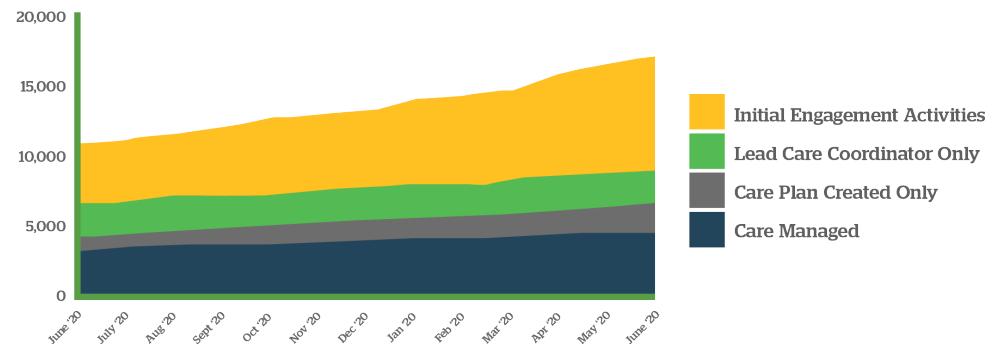


High medical,  
mental health,  
and/or social needs

### Care Management Rates:

Trending Metric Counts:

#### Count of Patients Engaged in Care Coordination Activities



### Process and Outcome Metrics

Key process and outcomes metrics will still be monitored using a simplified tool. Care Navigator will continue to be available for communication and collaboration

### Next Steps

Support the network in the transition to the 2022 Care Coordination Program

- Educate network on program changes
- Prepare network for simplified reporting requirements

# Core Capability: Network Performance Management

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## 2022 Network Accountabilities

- Patient panel management and outreach
- Care coordination
- Bi-annual care managed attestation (NEW)
- Care coordinator professional development
- Cross organizational collaboration and communication
- Process improvement



# Core Capability: Data and Analytics



## Actionable Data & Insights for Providers

### Participant Survey: Data & Analytics

#### Respondents use:

- static reports
- self-service analytic tools
- direct support

#### Improvement opportunities:

- data availability
- ease of use
- customized support

78% of network survey respondents said they currently use OneCare data for organizational decision-making:

- inform financial decisions
- quality improvement work
- workflow refinement
- coordinating within and across HSAs
- identify variations in care or quality



### OneCare analysts are:

- identifying opportunities for changes in workflow or improvement in quality of care
- interacting with participants to determine where data could support improvement efforts

### Featured OneCare tools and apps:

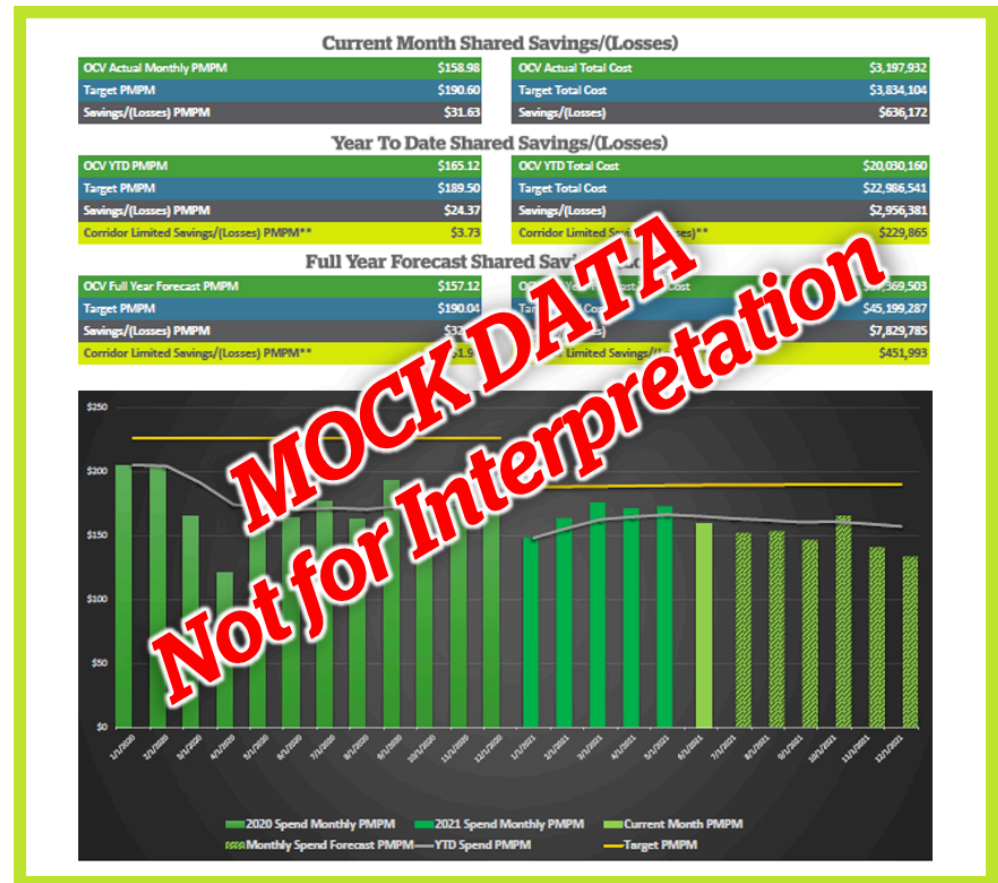
- OneCare Performance Dashboard
- Performance Dashboard Companion Application
- Inpatient Care Location Insights
- Influenza Vaccine Quality Improvement Initiative
- Hypertension and Diabetes Management

# Core Capability: Data and Analytics



## Financial Performance Report

- Designed to communicate total program savings/loss outcomes to participants
  - Current month
  - Year-to-date
  - Year-end forecast
- Cascades from aggregate results down to HSA and practice level financial outcomes
- Aggregates all program elements into one financial summary





# Core Capability: Data and Analytics



## Primary Care Panel Report

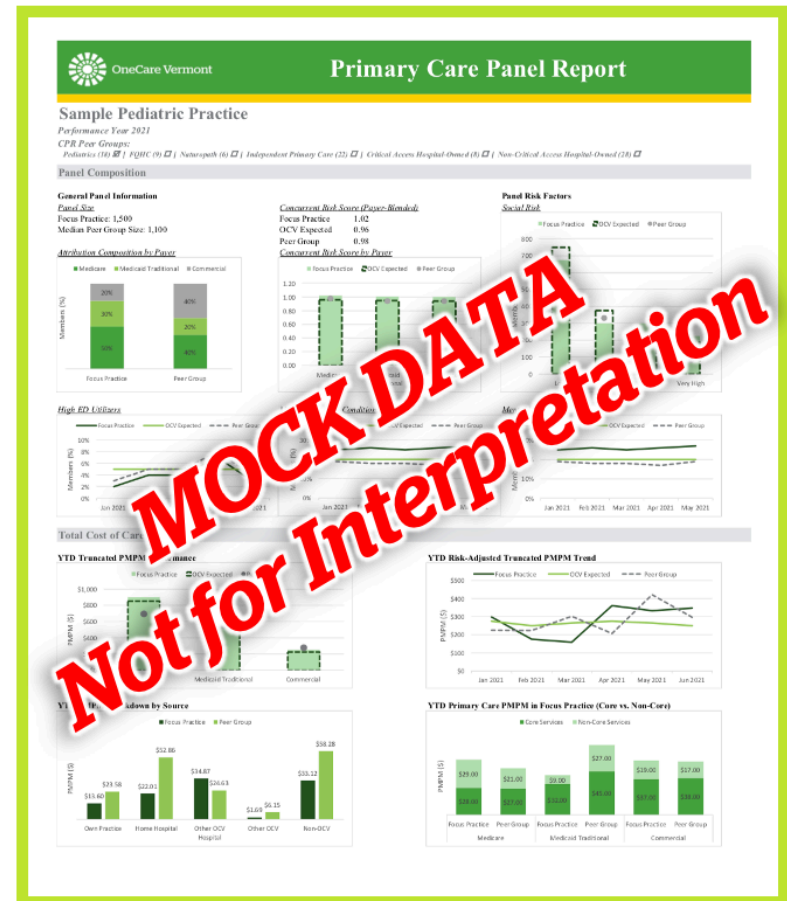
■ Designed to consolidate multiple data elements into one quarterly report

- Practice panel composition
- Total cost of care
- Utilization
- Quality

■ Performance benchmarked against a peer group of similar practices

■ Further research and analysis facilitated through:

- WorkbenchOne
- Direct OneCare support





## OneCare Vermont: **Data and Analytics**

<https://youtu.be/t1uJzyhtGqQ>

Find more videos about OneCare in our video center: [www.onecarevt.org/videos](http://www.onecarevt.org/videos)

# Core Capability: Payment Reform

## Fixed Payment Transformation



### Participant Survey: Payment Reform

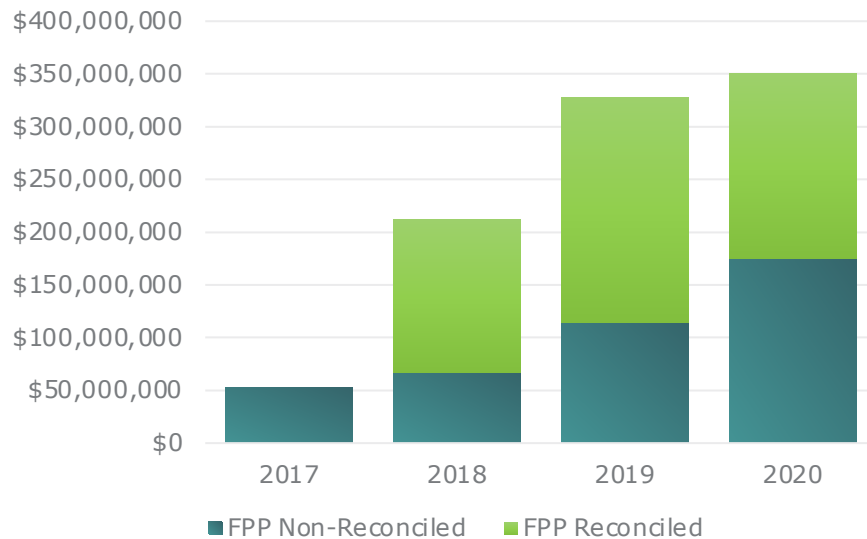
#### Highlights:

- Requests for additional supports
- Customize support to promote understanding of offerings and underlying models
- Technical and formatting enhancements to existing reports

### OneCare facilitates fixed payment conversions on behalf of its participants:

- Stabilizes provider revenue
- Stabilizes healthcare costs
- Shifts away from volume-based incentives

Fixed Payment Progression



# Core Capability: Payment Reform

## Fixed Payment Transformation

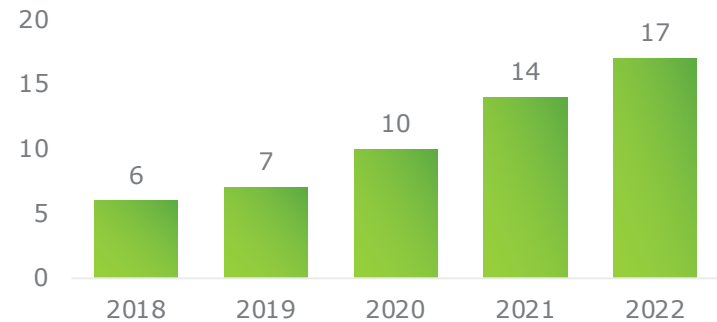


## Comprehensive Payment Reform Program

### Program to transition independent primary care practices to stable monthly fixed payments

- Monthly PMPM payments for “core” primary care services
- FFS+ reimbursement for other services offered within the primary care setting like:
  - Behavioral health
  - Procedures
  - Lab
- Supplemental PMPM to support care delivery evolution

### Participants by Year



### Hosted a series of focus groups in the summer of 2021

- Opportunity to collect feedback and ideas
- Provided input into 2022 program adjustments

# Lessons Learned

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- Network engagement takes time and dedication
- Participants deeply engaged in programmatic evolutions
- Commitment to care coordination affirmed
- Clinical prevention warrants more focus
- COVID-19 reinforced the importance of value-based care
  - Team-based care,
  - Coordination of care,
  - Payment reforms,
  - Use of data,
  - Alternate visit types/telehealth
- Providers recognize value in progressive capitated payment model



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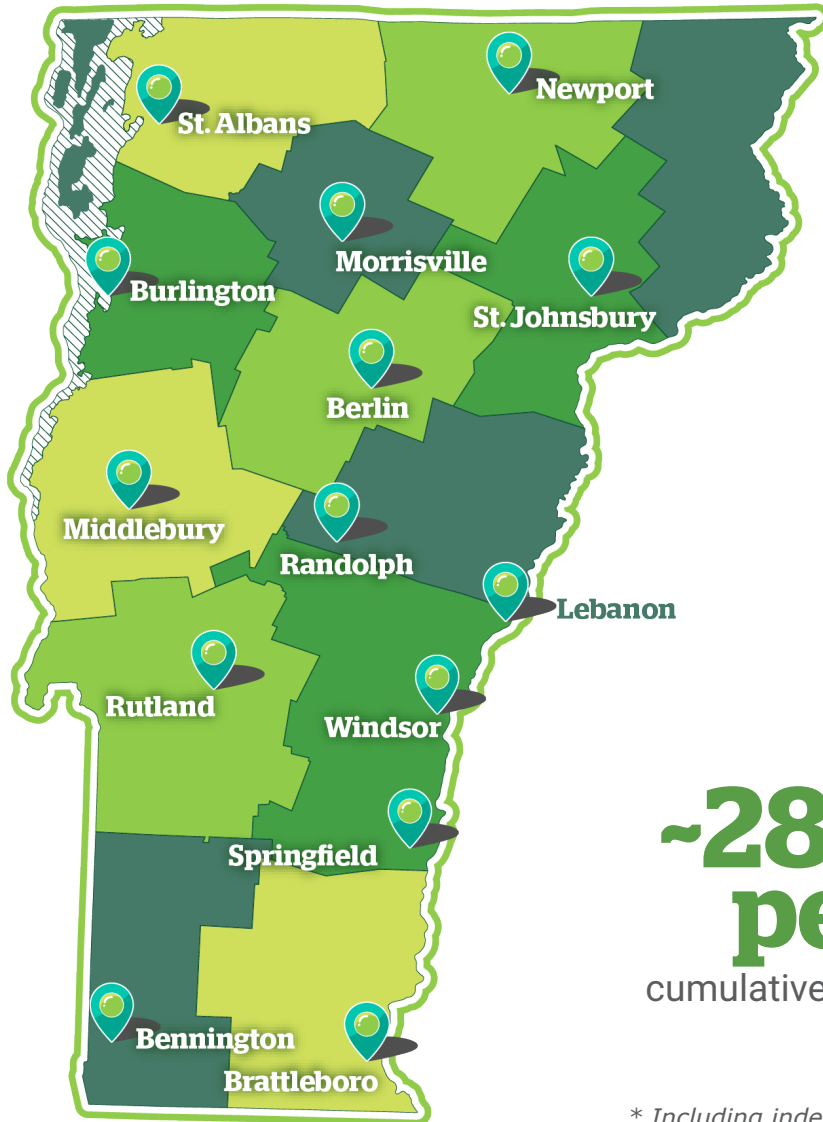
# **Budget Section 2**

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# **ACO Provider Community**



# 2022 ACO Map and Participants



- 14** Hospitals
- 121** Primary Care Practices\*
- 262** Specialty Practices\*\*
- 5060** Individual Providers
- 9** Federally Qualified Health Centers
- 22** Skilled Nursing Facilities
- 10** Home Health Agencies
- 5** Area Agencies on Aging
- 21** Regional Housing Authorities (SASH)
- 10** Designated Agencies for Mental Health & Substance Abuse

**~288,000  
people**  
cumulatively covered by payers



The number of  
attributed people  
**has grown  
nearly tenfold**  
from 29,100  
in 2017

\* Including independent primary care practices and hospital primary care practices

\*\* Including hospital and independents

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# **Budget Section 3**

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## **ACO Payer Programs**

# Value-Based Care Programs

Budget includes continuation of all payer programs offered in 2021

COVID continues to create challenges, but also reinforces the need for value-based care

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## Medicare

- Budget anticipates similar program design
- Trend rate budgeted per CMS forecast

## Medicaid

- No substantial changes incorporated into budget

## BCBSVT QHP & Primary

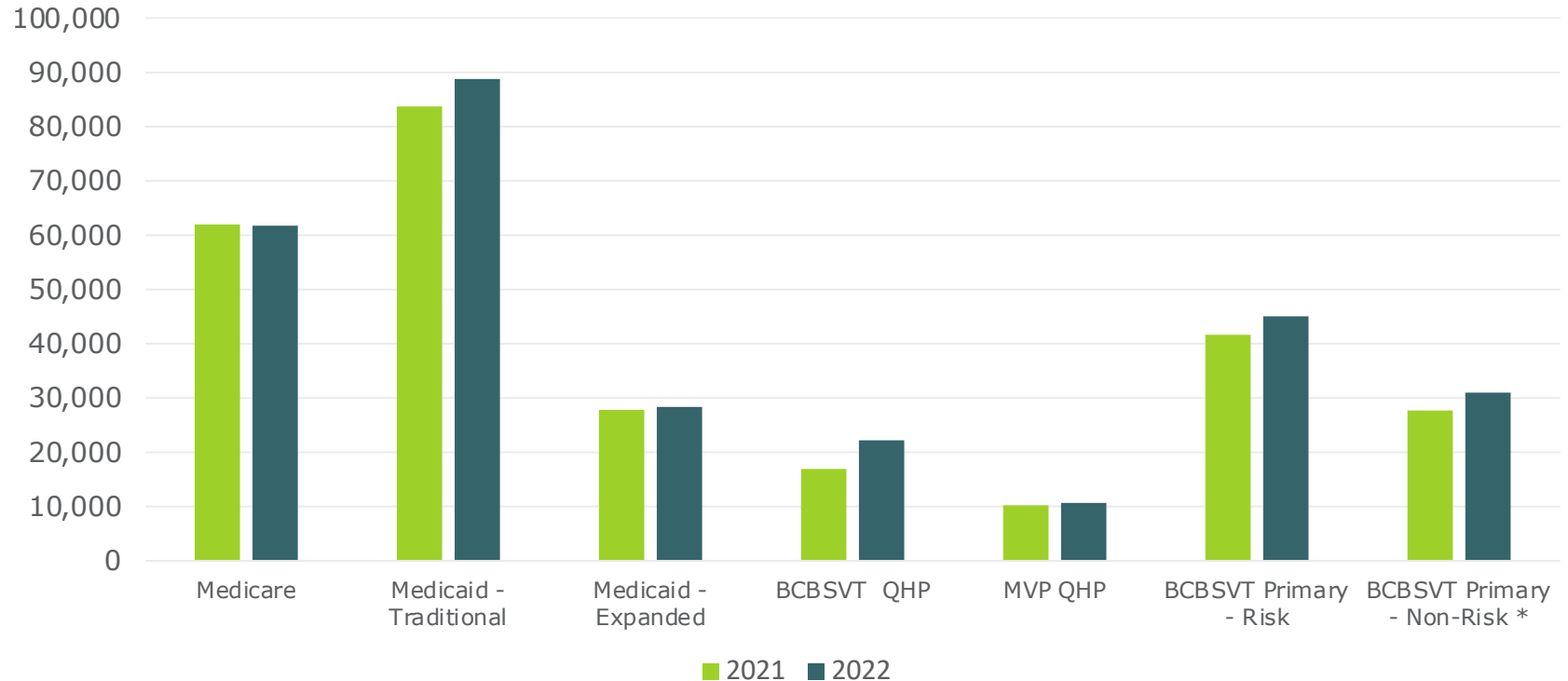
- Contracts merged into one
- No substantial changes incorporated into budget

## MVP QHP

- No substantial changes incorporated into budget



# Attribution by Program



## Budget Includes 288k lives; 257k expected to qualify for scale

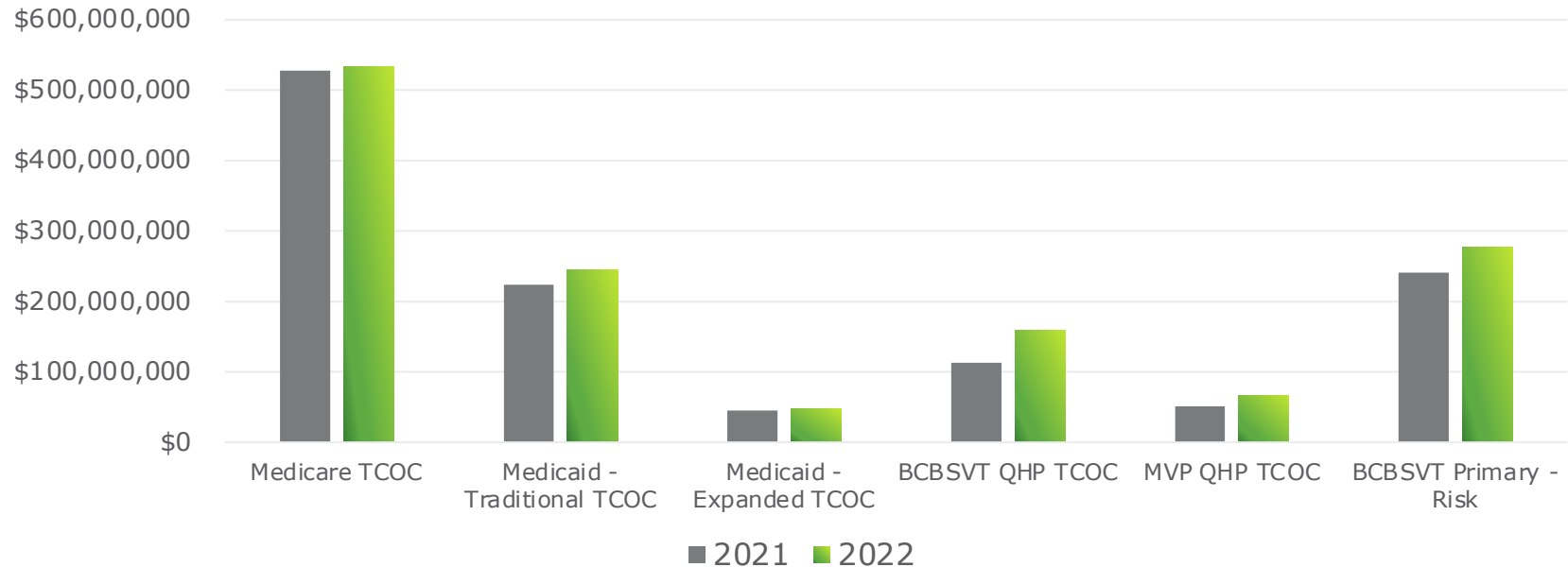
- Modest increase to Medicaid attribution expected
- Additional participation in BCBSVT programs expected to increase commercial attribution

\* Does not qualify for All-Payer Model scale

# **Budget Section 4**

## **Total Cost of Care**

# Estimated Health Care Accountability



## \$1.33B of Health Care Costs in Value-Based Contracts

- 2022 represents another year with significant healthcare costs included in a value-based model
- Impacts of the COVID pandemic make forecasting payer targets challenging
- Accountability growth follows attribution increases, insurance rate increases, COVID rebound, and other payer reimbursement modifications



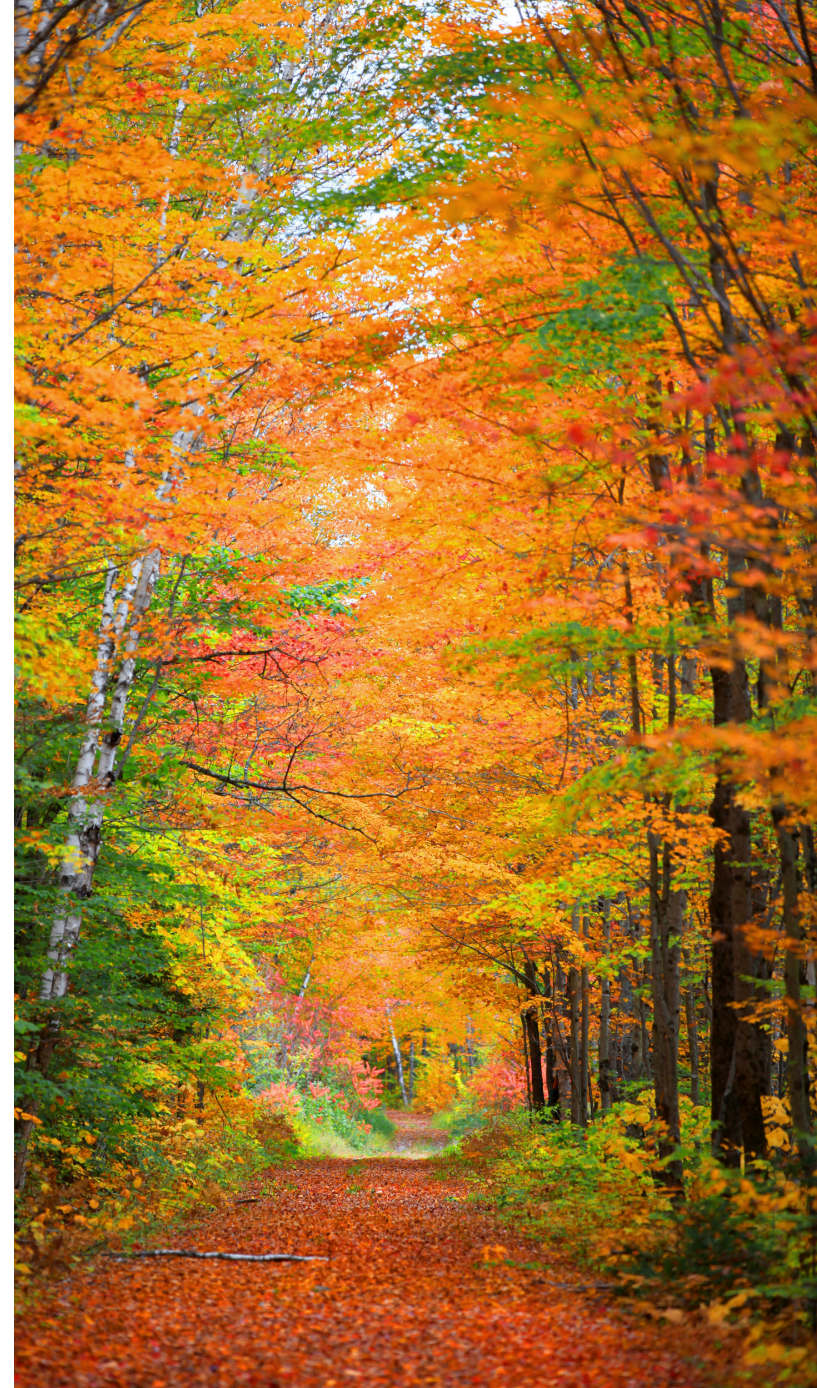
# Program Trend Rates

## Best available data are used to develop the total cost of care estimates

- In 2022 this is complicated by the fact that 2020 would typically be the “base year” for some programs
  - Conversations are ongoing as to how each payer will work around this unusual year
- Current healthcare patterns continue to evolve

## Unique Medicare program factors:

- End Stage Renal Disease (ESRD) and Non-ESRD components budgeted at the United States Per Capita Cost (USPCC) trend forecast
  - Supports providers and reform efforts
  - Potential to affect cost shift
- Multi-Payer Advanced Primary Care Practice (MAPCP) component budgeted conservatively at 3.5%
- Despite these assumptions, the Medicare trend rates will ultimately be established by the GMCB

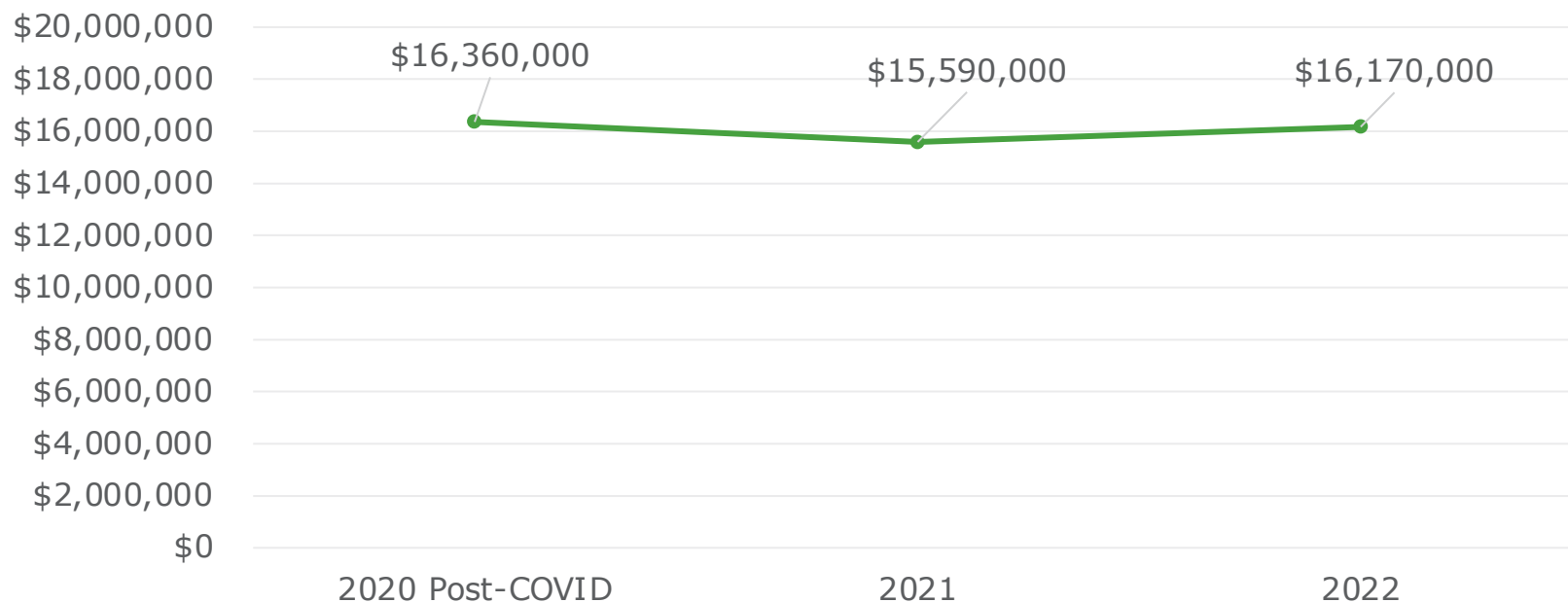


# **Budget Section 5**

## **Risk Management**

# Risk/Reward Levels Through the Pandemic

- Total cost of care forecasts are prepared for the purpose of estimating risk/reward opportunity
- While program terms are being actively negotiated, the budget assumes continuation of reduced risk levels in 2022 as the pandemic continues to disrupt healthcare patterns

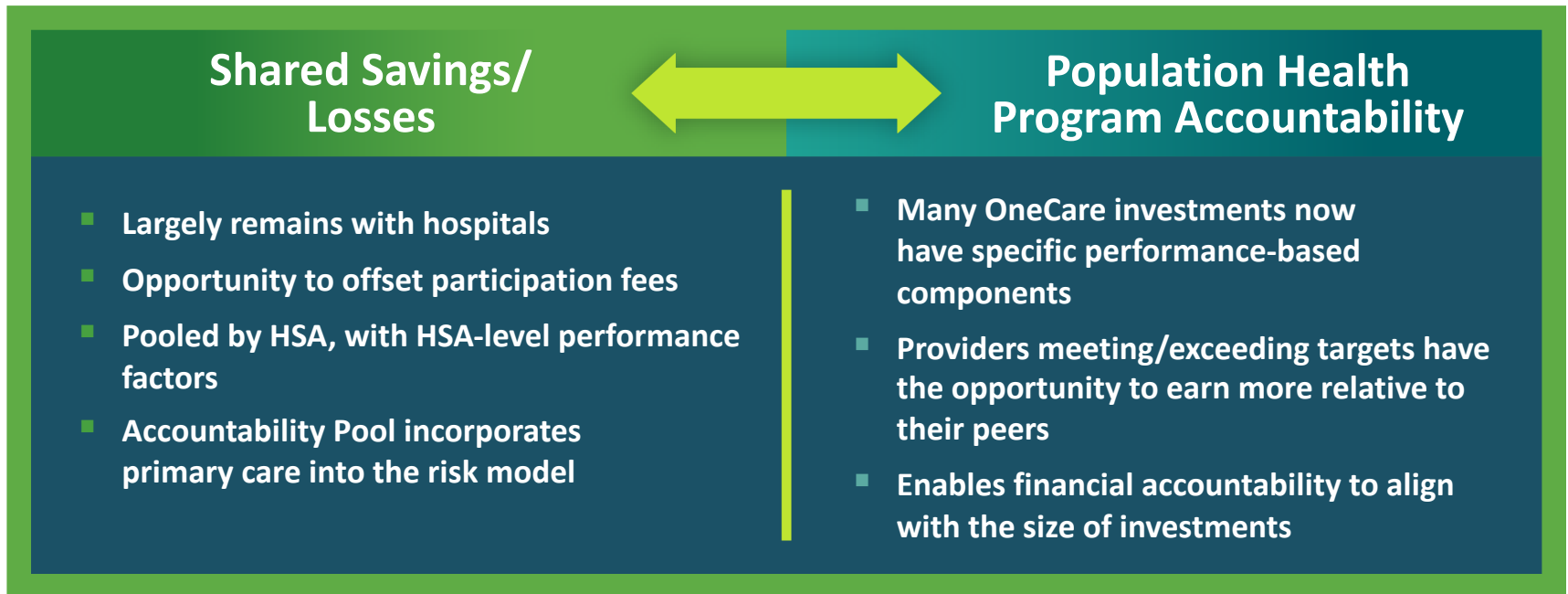


*\* Figures approximate the budgeted/estimated risk levels entering the performance year. The figures do not factor in COVID-related adjustments such as proration for the duration of the public health emergency.*

# Risk and Reward Model

- The risk model changed to a pooled approach in 2020 in response to COVID, actuarial concerns, and resource constraints
- In concert, PHM investments are evolving to include performance-based components

**Working together, these two elements spread accountability down to the individual practice level without overloading community providers with untenable risk.**



# Fixed Payments

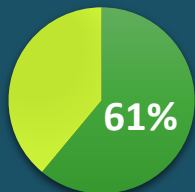
Underneath total cost of care (TCOC) accountability programs, OneCare is able to facilitate payment reforms for its providers.

OneCare's payment reform offerings are affected by:

- The contracted payer programs and the health care costs included within those contracts
- Whether or not the payer program offers a fixed payment option
- The size of the attributed population
- Proportion of care in-network vs. out-of-network
- Provider readiness

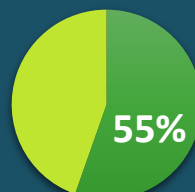
OneCare's fixed payment evolution can be determined by comparing the fixed payments to the in-network TCOC included in program contracts.

Public Payer Programs



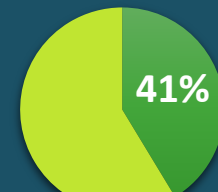
- Fixed Payments
- In-Network Fee-for-Service

All Programs w/ Fixed Pmts.



- Fixed Payments
- In-Network Fee-for-Service

All Programs



- Fixed Payments
- In-Network Fee-for-Service

*Note: 2021 data used to develop the pie charts*



# **Budget Section 6**

## **ACO Budget**



# Overview: \$44.1M Budget

## Balanced Budget

- No profit or loss
- No additional contributions to OneCare reserves

## Key Strategies

- Accommodate the end of Delivery System Reform and Health Information Technology revenue
- Continue focus on care coordination
- Sustain investments that have become reliable revenue streams for participating health care providers
- Maintain capacity to support the provider network

**\$28.9M**  
in Population  
Health Management  
program investments

**\$15.3M**  
in OneCare  
shared infrastructure



# Revenue Highlights

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## Landscape:

- The main challenge in the 2022 budget was accommodating the loss of Delivery System Reform (DSR) and Health Information Technology (HIT) funding
  - \$3.9M revenue loss
- Budget includes consistent reform investments through payer contracts
  - Revenue levels float with attribution
- Deferred funds accumulated through the pandemic largely consumed in 2021
  - Some remains for programs continuing into 2022
- \$3.6M increase in hospital participation fees needed to balance the budget



# Revenue Highlights

Area	2021 Revised	2022	Change
Payer Program Support	\$10,923,620	\$11,988,969	\$1,065,349
Blueprint	\$8,767,133	\$9,073,983	\$306,850
DSR Funding	\$2,900,000	\$0	(\$2,900,000)
Health Information Technology	\$1,000,000	\$0	(\$1,000,000)
Fixed Payment Allocation	\$3,354,110	\$3,360,439	\$6,329
Other Revenues	\$3,993,990	\$1,062,121	(\$2,931,869)
Hospital Participation Fees	\$15,056,520	\$18,696,155	\$3,639,635
<b>Total</b>	<b>\$45,995,373</b>	<b>\$44,181,667</b>	<b>(\$1,813,706)</b>

# Expense Highlights:

## Population Health Management

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### Landscape:

- In light of the revenue loss, the budget aims to protect as much of the population health investments as possible
- Investments in care coordination were specifically identified as an area to sustain funding
  - Care coordination is at the epicenter of many ACO models
  - Requires hospital investment to sustain
- Despite some necessary changes to certain programs, OneCare is able to sustain \$28.9M of funding to participating providers



# Expense Highlights: **Population Health Management**

## Care Coordination

- Significant effort to maintain this program; some reductions required
- Funding model moving off of Care Navigator
- Each payment stream has a component for outcomes/performance
- Continuation of the Longitudinal Care Program
- Reduced DULCE expense for OneCare
  - Program maintained in full through additional support from VDH

## PCP Engagement Payments

- The revenue that historically supported these payments will be reallocated to help sustain the care coordination program

## Value-Based Incentive Fund (VBIF)

- Continuing to move toward a payer-blended approach that enables OneCare to reward providers for high-quality care
  - Timely payments
  - Practice-specific quality scores



# Expense Highlights: **Population Health Management**

## Prevention

- Budget includes six months of RiseVT funding in the same form
- Work beginning to determine the next iteration of clinical prevention and health equity

## Blueprint

- Aggregate 3.5% inflation

## Payment Reform Programs

- CPR program expansion anticipated in 2022: two additional practices
- Working on pilot with FQHCs for anticipated 2023 launch

## Specialist / Innovation

- No new expenses; all expenditures represent continuation of previously funded initiatives





# PHM Investment Areas

Investment Area	Amount	Focus & Purpose
Primary Care Services	\$10,789,077	Payments to primary care intended to supply resources to focus on population health initiatives
Care Coordination	\$6,753,948	Payments designed to encourage enhanced coordination and communication of patient care; Longitudinal Care; DULCE
Quality	\$1,527,247	Programs and payments designed to incentivize high-quality care
Primary Prevention	\$215,000	Investments in prevention programs
Specialty / Innovation	\$534,873	Investments for innovative program pilots with the opportunity to improve care and drive success under program goals
Blueprint Programs	\$9,073,983	Supports and Services at Home (SASH), Community Health Team (CHT), and Patient Centered Medical Home (PCMH) payments
<b>Total</b>	<b>\$28,894,128</b>	<b>Total funding opportunity</b>

# PHM Investment Recipients

Provider Type	Amount	Programs
Hospital / Hospital PCP	\$9,921,295	Population Health Mgmt. Program, Complex Care Coordination Program, Value-Based Incentive Fund, Primary Prevention, Specialist Program, Innovation Fund, PCMH Payments, Community Health Team Payments, Reinvested VBIF Quality Initiatives
Independent PCP	\$6,263,893	Population Health Mgmt. Program, Complex Care Coordination Program, Value-Based Incentive Fund, Comprehensive Payment Reform Program, PCMH Payments
FQHC	\$4,867,996	Population Health Mgmt. Program, Complex Care Coordination Program, Value-Based Incentive Fund, Primary Prevention, PCMH Payments, Community Health Team Payments
Specialist	\$120,000	Value-Based Incentive Fund
Designated Agency	\$1,029,452	Complex Care Coordination Program, Value-Based Incentive Fund, Specialist Program, Innovation Fund
Home Health	\$1,459,000	Complex Care Coordination Program, Value-Based Incentive Fund, Longitudinal Care
Area Agency on Aging	\$258,301	Complex Care Coordination Program, Value-Based Incentive Fund
SASH	\$4,285,795	SASH
Community	\$50,000	Community entities
Other / TBD	\$638,395	Parent Child Centers, <i>TBD</i>
<b>Total</b>	<b>\$28,894,128</b>	

# Expense Highlights: Operations

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## Landscape:

The resource demands from the provider network are higher than ever – and this is a good thing.

- *Participants are asking for additional data, insights, and direct support*
- *OneCare continues to operate a complex suite of value-based ACO programs*
- *Participants need support in understanding their roles and implementing their accountabilities*
- *This is a **learning organization**, and incorporating new findings and insights in a way that includes network input and feedback takes resources*

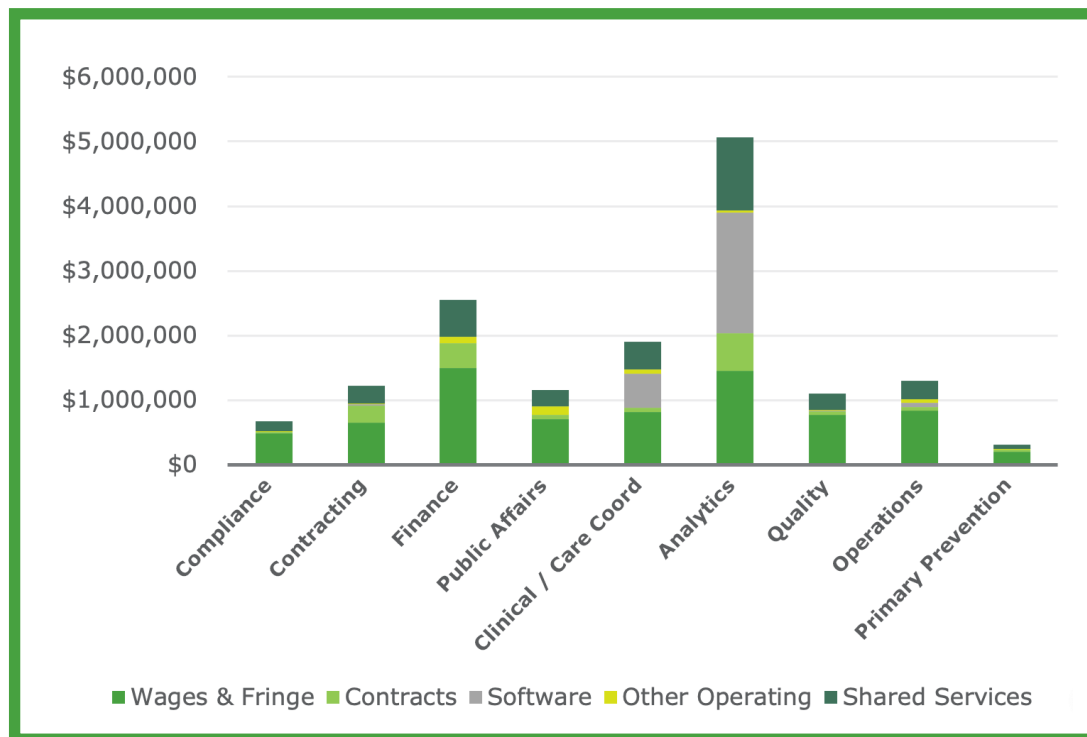
In addition, staff needs time to meet demands outside of provider support, which limits the time that can be dedicated to participating providers and ACO activities



The operating budget aims to sustain the capacity to continue supporting participating providers, and also being mindful of the costs charged to hospitals.

# Expense Highlights: Operations

	2021	2022	Change
Salaries, Payroll taxes & Fringe	\$9,646,062	\$9,651,315	\$5,253
Software/Informatics Tools	\$3,604,919	\$2,516,505	(\$1,088,414)
Consulting, legal and purchased services	\$1,147,448	\$1,193,249	\$45,801
Supplies, Travel, and Other	\$1,507,230	\$1,926,469	\$419,239
<b>Total</b>	<b>\$15,907,679</b>	<b>\$15,289,560</b>	<b>(\$618,120)</b>

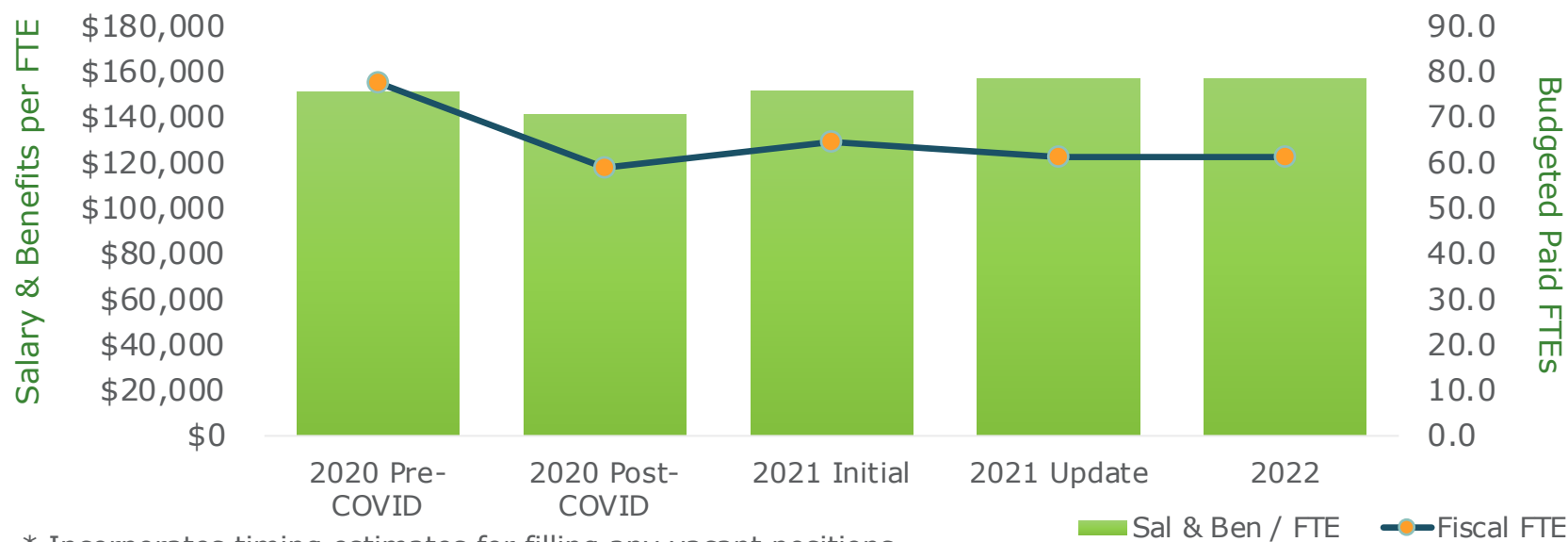


- \$618k expense reduction
- Supplies, Travel, Other category includes reclass of software professional services
- Salaries: Comparable staffing model
- Software: Restructuring of VITL contract; reclass of software professional services

# Expense Highlights: Operations

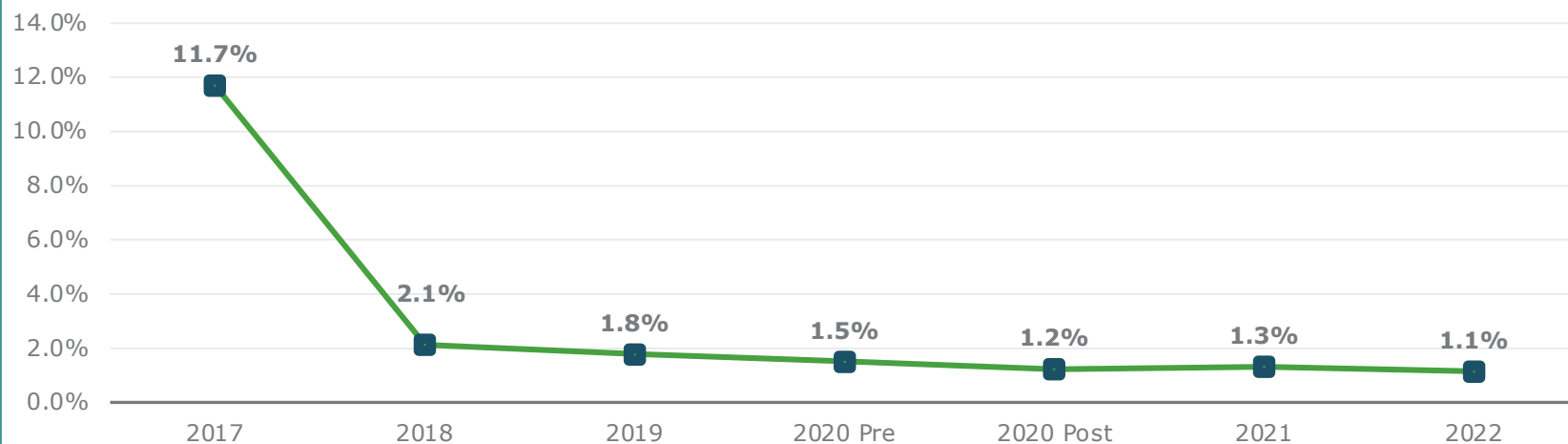
Staffing remains the single largest operational investment. Operations continue with 16.35 fewer FTEs than planned in the 2020 Pre-COVID budget.

Staffing					
	2020 Pre-COVID	2020 Post-COVID	2021 Initial	2021 Update	2022
Full Workforce FTEs	77.75	67.26	64.65	67.50	61.40
Budgeted Paid FTEs *	77.75	59.03	64.65	61.37	61.40

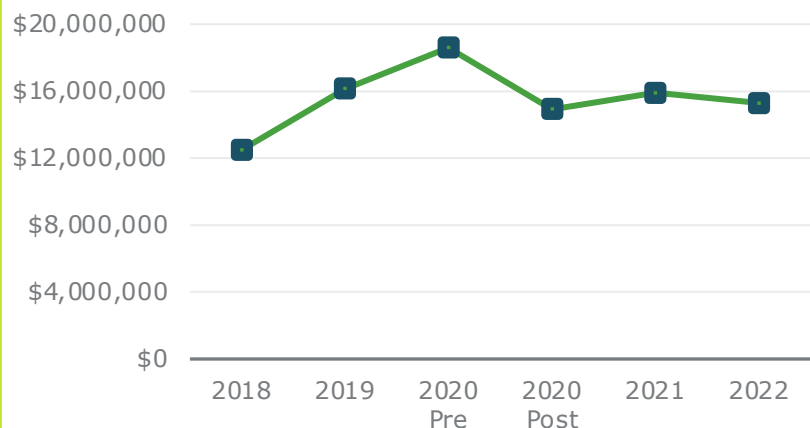


# Expense Highlights: Operations

## Operating Cost as % of TCOC



## Operating Costs Over Time

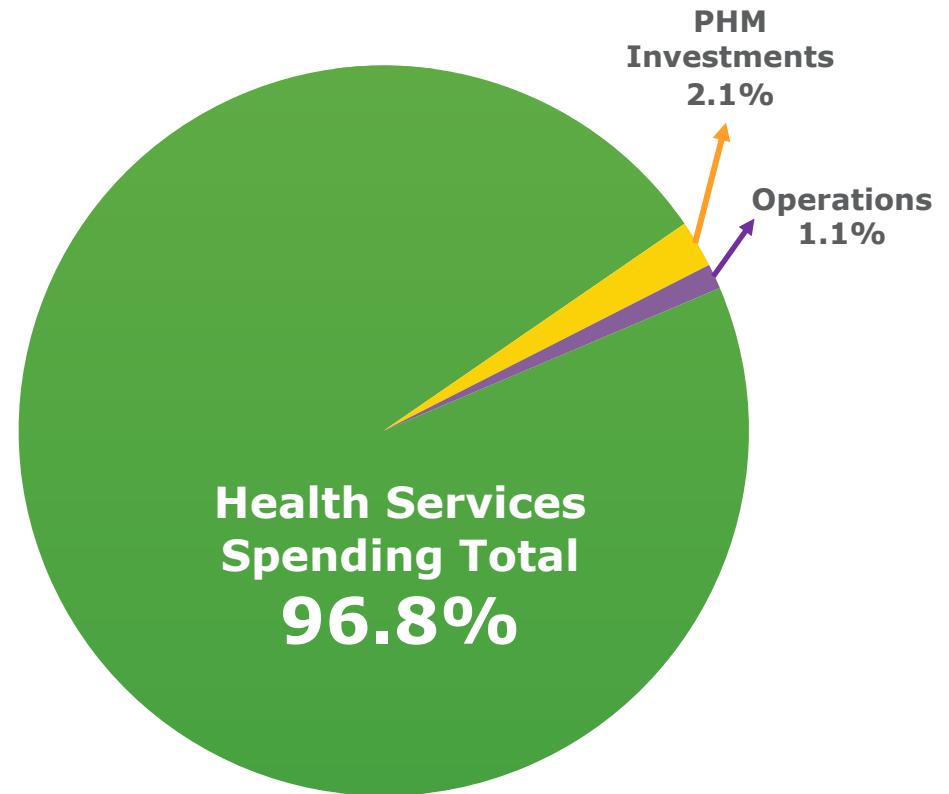


- OneCare reduced its operating expenses significantly to support the providers who fund ACO programs and activities
- The operating expense budget remains at this lower level through 2022
- Maintaining this level limits OneCare's ability to take on new initiatives



# Full OneCare ACO Accountability Budget

Summary Income Statement	2022 Budget
TCOC Targets	\$1,330,238,159
Payer Contract Rev.	\$11,988,969
Other Revenues	\$4,422,559
Hospital Dues	\$18,696,155
<b>Total Revenue</b>	<b>\$1,365,345,842</b>
Health Services	\$1,321,164,176
PHM Investments	\$28,894,128
Operating Costs	\$15,287,538
<b>Total Expenses</b>	<b>\$1,365,345,842</b>
<b>Gain (Loss)</b>	<b>\$0</b>



# Income Statement

Income Statement *	2022 Budget
Medicare TCOC	\$524,136,820
Medicare - Blueprint Obligation	\$9,073,983
Medicaid - Traditional TCOC	\$245,245,465
Medicaid - Expanded TCOC	\$47,558,217
BCBSVT QHP TCOC	\$159,654,505
MVP QHP TCOC	\$66,924,423
BCBSVT Primary - Risk	\$277,644,746
<b>TCOC Targets Total</b>	<b>\$1,330,238,159</b>
Payer Program Support	\$11,988,969
DSR Funding	\$0
Health Information Technology	\$0
Fixed Payment Allocation	\$3,360,439
Other Revenues	\$1,062,121
Hospital Dues	\$18,696,155
<b>Total Revenue</b>	<b>\$1,365,345,843</b>
FFS Spend	\$875,282,023
Fixed Payment Spend	\$445,882,154
<b>Health Services Spending Total</b>	<b>\$1,321,164,176</b>
Population Health Management Payment	\$9,457,821
Complex Care Coordination Program	\$6,549,463
Value-Based Incentive Fund	\$1,527,247
DULCE	\$204,485
CPR Program	\$1,331,256
Primary Prevention	\$215,000
Specialist and Innovation	\$534,873
PCP Engagement	\$0
SASH	\$4,285,795
Blueprint PCMH	\$1,993,092
Blueprint CHT	\$2,795,095
<b>Total PHM Investments</b>	<b>\$28,894,128</b>
General Operations	\$15,287,538
Risk Protection	\$0
<b>Total Infrastructure</b>	<b>\$15,287,538</b>
<b>Total Expenses</b>	<b>\$1,365,345,843</b>
<b>Gain (Loss)</b>	<b>\$0</b>

# Balance Sheet

Balance Sheet	2022 Budget
Cash	20,350,000
Restricted Cash	3,900,000
<b>Total Cash, Investments, &amp; Reserves</b>	<b>24,250,000</b>
Accounts Receivable	2,200,000
Accounts Receivable from Participants - Contract Risk Settlement	-
Accounts Receivable from Payers - Contract Risk Settlement	-
Prepaid Expenses and other current assets	275,000
<b>Total Current Assets</b>	<b>26,725,000</b>
Board Designated Assets	-
Property, Plant And Equipment, net	30,000
Other Long-Term Assets	-
<b>Total Assets</b>	<b>26,755,000</b>
Accrued Expenses/NW Payable	15,718,574
Accounts Payable to Participants, Contract Risk Settlement	-
Accounts Payable to Payers, Contract Risk Settlement	-
Due to UVMMC	4,100,000
Due to DHH	-
Deferred Revenue	1,250,000
Debt	-
Other Current Liabilities	-
Designated Risk Reserve Fund Balance	-
<b>Total Current Liabilities</b>	<b>21,068,574</b>
Long Term Liabilities - Deferred Revenue	-
Long Term Liabilities - Other	-
<b>Total Liabilities</b>	<b>21,068,574</b>
Capital Contributions	-
Retained Earnings	-
OneCare Net Assets	5,686,426
<b>Total Equity</b>	<b>5,686,426</b>
<b>Liabilities and Equities</b>	<b>26,755,000</b>

\* The income statement is displayed in a non-GAAP manner in order to transparently display the scope of 2022 operations

# OneCare's work towards making steady advancements in value-based care adoption

## **Successes**

1. **Growing engagement**
  - Broad accountability and engagement across 162 independent organizations
  - Increasing attribution
2. **Continual commitments to population investments and approach in support of delivery reform**
3. **Advancing innovative payments models linked to outcomes and quality**
4. **Delivering on fixed predictable payments for payers and providers**

### **Top Three Facilitators for Maximum Success\***

-  **Provider Interest**
-  **Health Plan Interest/Readiness**
-  **Government Influence**

\*HCP-LAN survey

## **Future Opportunities**

**Move away from fee-for-service lookback as the basis for target setting**

**Maximizing risk/reward in alternative advanced payment models**

**Models that support rural high value/low-cost providers**